All letters are subject to editing and may be shortened. General letters can be sent to bjgpdisc@rcgp.org.uk (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication. For submission instructions visit: bjgp.org/letters

Editor's choice

It would be very easy to see primary care as an unattractive career option for young doctors. The government, media and other doctors repeatedly disparage our profession. You can imagine my delight when I received the following reflection by our undergraduate medical student.

"Until recently I didn't want to become a GP. I've always assumed general practice lacked excitement and wasn't intellectually stimulating. However, during my primary care placement, I realised the rewarding aspect of medicine is the privilege of helping others. My time at Friarwood Surgery changed my attitude towards primary care. I now want to become a GP."

Medicine is a science, but being a good doctor involves being able to listen and communicate. I had witnessed how communication failures in hospitals left GPs to console confused or angry patients. I learnt that to take a good history you must understand the patient's story.

My previous assumptions concerning general practice were completely flawed. How can general practice be intellectually inferior? The varied presentations make diagnoses incredibly difficult. And how can it not be exciting? You literally have no idea what will come through your door. That first consultation builds a relationship that can last until the end of a patient's life.

General practice is where doctors really help people, by addressing their fears, understanding their beliefs and providing care to suit them. This is where the real medicine happens and that is why I want to be a GP."

I could not have put it better myself.

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Paying for the NHS

It is unlikely that any real reforms of the NHS will appeal to politicians since they have reasons for keeping the status quo. Why not set up an independent expert body as the main overseer of the NHS, with satellites in all major areas? This would rid the government of the millstone round its neck.

This country is awash with money. Charities raise huge sums of money for good causes. What better cause than the NHS? Taxes on the causes of ill health such as alcohol, tobacco and excessive sugar in food and drink could be fed straight into the NHS budget. Gambling has a huge financial turnover and taxing winnings could raise millions. Everyone in a hospital catchment area could be invited to subscribe to a hospital fund. Industry benefits directly from an efficient health service and could subsidise local needs from tax-free profits. During WW II, even small towns had 'thermometers' depicting progress towards the purchase of a Spitfire. If the population as a whole felt the NHS belonged to and was supported by them, hospital closures would become a thing of the past.

National Insurance never did pay for the NHS. A true national insurance scheme would create a core for the main expenses of the NHS. Add Government-backed insurance with all the insurers in the UK. A dedicated lottery and local fundraising would remove the money worries of the NHS.

Limiting the unreasonable demands by patients needs education. The NHS and self help should be part of the national curriculum, bringing professionals into schools, colleges, and universities, and improving knowledge of a healthy lifestyle.

There are no insoluble problems in the NHS. Give the public incentives to voluntarily contribute to their local services so that the NHS really becomes our NHS and not a political plaything. Fund it by any legal means available and we could all become proud of the NHS and it could truly become the best health service in the world.

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Author's response

Van Marrewijk *et al* raise a number of useful questions about our study in their letter.¹ There are no conflicts of interest among the GPs studied which would impact on reduction in self-monitoring of blood glucose that was demonstrated. No payment was made to them for taking part in this evaluation and no payment was used to incentivise reduction.

I think it highly unlikely that socioeconomic factors had any substantive impact on the greater reduction in the two intervention CCGs. All three CCGs share very similar socioeconomic profiles.

I agree that the assumption that the same reduction can be achieved nationally is just an assumption and we gave indicative costs were this to be achieved. Making the reduction may be a little more difficult because in these CCGs we have a 'home advantage' and strong track record of successful improvement programmes supported by IT and a University improvement group, which are not necessarily simply applicable across all CCGs.

Lastly the early decrease is in part due to extensive discussions that took place with stakeholders in the 2 years before formal implementation, which influenced prescribing behaviour. This included diabetes specialist nurses, hospital specialists, prescribing advisors, patients, pharmacists, CCG and practice staff, and GPs. Getting an initial local consensus is a key component of change and requires quite a lot of time, usually at least a year, to achieve a major change like this.

We do agree that a randomised trial would have been a better study but there are some practical difficulties in randomising CCGs that might need to be overcome in order to achieve this. Some imaginative thinking on design might be needed along with far greater resources than we had at our command. We had no special funding for this study.

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1. Robson J, Smithers H, Chowdhury T, *et al*. Reduction in self-monitoring of blood glucose in type 2 diabetes: an observational controlled study in east London. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X684421.

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